

Department of Public Health and Human Services Medicaid/Special Health Services Orthodontia Treatment Plan

Name:	Provider Name: Tax ID #:
DOB:	Medicaid Provider #
Address:	Address
Phone:	Phone: FAX:
Health Insurance: Number:	Signature:

For Category A complete the following information, include appropriate Phase of Treatment and submit to SHS, 1400 Broadway, POB 202951, RmC-314, Helena, MT, 59620 or FAX to SHS at 406-444-2606. For questions, contact SHS at 406-444-3622. See reverse for Phase of Treatment information. Please submit additional comments separately. **For Category B**, complete the following information, include Phase 0 information and submit to Consultec POB 8000, Helena, MT, 59620; Include x-rays, molds, and or photographs.

Molar Relationship

Class I ☐
Class II ☐
Class III ☐
Class III Facial ☐

Habits

Tongue Thrust Swallow ☐ Thumb/finger ☐
Large Tonsils/Adenoids ☐ Muscle Strain ☐
Clenching Teeth/Grinding ☐ Mouth Breathing ☐

Oral Hygiene

Excellent ☐ No plaque present
Good ☐ Plaque present on some tooth surfaces
Fair ☐ Plaque present & covering < ½ of all tooth surfaces
Poor ☐ Plaque present & covering > ½ of all tooth surfaces

Areas of Concern: Crossbite ☐ Missing Teeth ☐ Impaction ☐ Frenum Abnormality ☐
Cleft Lip &/or Palate ☐ Gum Defects ☐ Extra Teeth ☐ Craniofacial Anomaly ☐

DPHHS Authorization

PHASE 0 Interceptive Orthodontia for Medicaid recipients only; Category B

Appliances: Hyrax ☐ Quad Helix ☐ Hass ☐

Reverse Headgear/Face mask ☐

Retainers ☐ Other ☐ _____

TREATMENT RECOMMENDATIONS

DENTAL DEVELOPMENT

ABCDE|FGH I J
TSRQP|ONMLK

8 7 6 5 4 3 2 1|1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1|1 2 3 4 5 6 7 8

Treatment Goal: Crossbite Correction

Anterior x-bite ☐ Posterior x-bite ☐

Length of Treatment: _____

Cost: _____

Start Date: _____

Category A

Over for Phase I through IV

PHASE I Early Expansion with RetentionAppliances: Hyrax ☐ Quad Helix ☐ Hass ☐Reverse Headgear/Face mask ☐Retainers ☐ Other ☐ _____
_____**TREATMENT RECOMMENDATIONS**

Oral Surgery Recommendations:

8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8

Exposure At: _____

Treatment Goal: Maxillary Expansion

Length of Treatment: _____

Cost: _____

Start Date: _____

PHASE II Partial Banding with RetentionAppliances: Hyrax ☐ Quad Helix ☐ Hass ☐Reverse Headgear/Face mask ☐Retainers ☐ Other ☐ _____
_____**TREATMENT RECOMMENDATIONS**

Oral Surgery Recommendations:

8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8

Exposure At: _____

**Treatment Goal: Maxillary Development;
Dental alignment with mixed dentition**

Length of Treatment: _____

Cost: _____

Start Date: _____

PHASE III Banding with RetentionAppliances: Hyrax ☐ Quad Helix ☐ Hass ☐Reverse Headgear/Face mask ☐Retainers ☐ Other ☐ _____
_____**TREATMENT RECOMMENDATIONS**

Oral Surgery Recommendations:

8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8

Exposure At: _____

**Treatment Goal: Maxillary Development;
Alignment of Permanent Dentition; Retention**

Length of Treatment: _____

Cost: _____

Start Date: _____

PHASE IV Presurgical, Surgery, & RetentionAppliances: Hyrax ☐ Quad Helix ☐ Hass ☐Reverse Headgear/Face mask ☐Retainers ☐ Other ☐ _____
_____**TREATMENT RECOMMENDATIONS**

Oral Surgery Recommendations:

8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8

Exposure At: _____

**Treatment Goal: Maxillary Development;
Alignment of Permanent Dentition; Retention**

Length of Treatment: _____

Cost: _____

Start Date: _____

DENTAL SERVICE PRIOR AUTHORIZATION REQUEST

STATE OF MONTANA - SOCIAL and REHABILITATION SERVICES

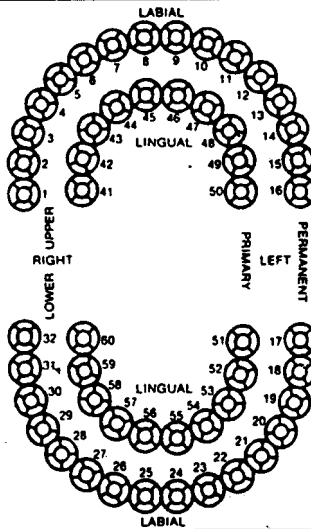
FOR USE BY DENTISTS/DENTURISTS

PLEASE TYPE OR PRINT

FORM NO. MA-4PA

NAME & ADDRESS OF PROVIDER OF SERVICES		PROV. NO.	MAIL TO: MONTANA MEDICAID DEPT. MA-4 P.O. BOX 8000 HELENA, MT 59604 TELEPHONE NUMBER 1-800-624-3958				
PATIENT: LAST NAME		FIRST	MIDDLE INITIAL	M <input type="checkbox"/> S <input type="checkbox"/> F <input type="checkbox"/> SEX	DATE OF BIRTH MO. DAY YEAR		INDIVIDUAL NUMBER

SURFACE NO.	TOOTH NUMBER	PROCEDURE NUMBER	DESCRIPTION OF SERVICE	EXPECTED DATE OF SERVICE	NO. SVCS.	CHARGES	APPROVAL	
							YES	NO
1								
2								
3								
4								
5								
6								
7								
8								



REASON FOR REQUESTED PROSTHESIS/SIGNS AND SYMPTOMS	PROSTHESIS (COMPLETE ONLY IF BEING REQUESTED)	
	DATE INSERTION OF LAST PROSTHESIS MO. DAY YEAR	TYPE OF LAST PROSTHESIS
	DATE OF LAST EXTRACTION MO. DAY YEAR	TYPE OF PROSTHESIS REQUESTED
	IS THIS A NEW PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE OF SERVICE IF OTHER THAN OFFICE _____	
If the patient chooses to use a dentist, please complete this prescription block and give the form to the patient. The patient will take the form to the dentist who will complete the rest of it and submit it for approval.		
R ^x Patient Name _____ Signature of Prescribing Dentist _____ Date _____		

CHARTING SYMBOLS	ABBREVIATIONS	Authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The recipient must be Medicaid Eligible on the date of service or date the prosthesis is received by the recipient. Authorization is valid for 180 days from the date of approval, if the patient is eligible on the date the services are rendered.
■ SURFACES TO BE FILLED / TEETH TO BE EXTRACTED x MISSING TEETH	1 - MESIAL 2 - DISTAL 3 - OCCLUSAL 4 - LINGUAL 5 - INCISAL 6 - FACIAL A - AMALGAM S - SILICATE P - PLASTIC C - CROWN G - GOLD	

FOR ORTHODONTIA REQUESTS ONLY; TO BE COMPLETED BY REQUESTING DENTIST NUMBER OF MONTHS OF SERVICE REQUESTED _____ ESTIMATED START DATE OF TREATMENT _____	CONSULTANT'S COMMENTS: _____ _____ _____ DATE: ____/____/____	ORTHODONTIA APPROVAL MONTHLY ADJUSTMENT _____ MONTHS APPROVED RETAINER SERVICE _____ MONTHS APPROVED OTHER _____
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SIGNATURE OF PROVIDER REQUESTING AUTHORIZATION _____

DATE _____

APPROVED BY _____

DATE _____

NOTE: This form will not be returned to you. You will receive notification through the MEDICAID R.A. or a letter.